What works? What fails?

FINDINGS FROM THE NAVRONGO COMMUNITY HEALTH AND FAMILY PLANNING PROJECT

Vol. 3, No. 1 Navrongo Health Research Centre

A NEW BEGINNING

DR. JOHN E. WILLIAMS, CO-INVESTIGATOR, CHFP

"That the Community Health and Family Planning Project (CHFP) has made remarkable progress in finding feasible means of re-introducing a Primary Health Care (PHC) system in rural Ghana cannot be disputed much. Even the die-hard skeptics will admit that the project has made some headway in bringing healthcare closer to the doorstep of the people who often need it most—the poor rural dwellers, who incidentally constitute the majority of our people.

Dr. John E. Williams—anything up his sleeve?

The Ghana Health Service has recognised the innovations, which were rigorously tested in Navrongo, as the way forward in addressing many of the nagging problems of our health-care system. The Community-based Health Planning and Services (CHPS) Initiative is a major shift in paradigm for a health service which for a long time had become bogged down by inefficiency, stasis, and lack of dynamism. CHPS should provide a new way of doing things and with it should come some welcome freshness and hopefully, endless opportunities for health managers who are willing to innovate.

This may start to sound like a fairy tale with the ending 'and they all lived happily ever after'. The question is, is this the end? Have we done all that can be done with the opportunities we've had? Probably, we would need to examine our dear CHFP again as well as ourselves, and ask the questions that need to be asked and answered before we start to pat ourselves on the back and say goodbye to one of the cornerstones of the NHRC. The saying goes that every good thing has an end. Whether we like it or not, the CHFP will not continue forever and will one day breathe its last.

A critical examination of the CHFP, with its objectives in mind, reveals that it has demonstrated quite well, a new context within which services can be delivered. What about the content of what has been delivered so far? Can we say we are satisfied or is there room for improvement?

The CHFP has played host to several teams of district health workers from all over the country, all of them with the sole purpose of coming to see the 'Navrongo Experiment' firsthand. At debriefing sessions at the end of these visits, our CHOs have often been commended for working hard under difficult conditions and making genuine efforts to do their best for their communities. However, one often gets the feeling that the exposure we give our guests demystifies their feelings about Navrongo and probably, their rather high expectations about top-notch services being delivered here in the Kassena-Nankana district. I can even imagine them saying to themselves that we can do better than this!

Yes, so we have shown that it is feasible to deploy CHOs into remote community locations. We have also shown that volunteers can be deployed to assist the CHOs successfully if supervision is adequate and comprehensive. Our community mobilisation efforts are also well known. Are we willing to reach within ourselves to admit that there is unfinished business, without causing others to suspect that we could be harbouring base motives? Maybe we just want the CHFP to go on and on and on until the end of time, so that our salaries and allowances will keep rolling in!

Methinks our motives are more honourable than that! In the life of this project, many ideas have surfaced, not all of which have seen the light of day as far as implementation is concerned. One of these 'bright' ideas is the incorporation into the project of an emergency obstetric care programme.

Following the International Conference on Population and Development (ICPD) in Cairo in 1994, all countries were encouraged to make efforts to provide integrated reproductive health services. One would not just be vigorously promoting family planning without being concerned about the other reproductive health needs of couples and individuals. The CHFP has equipped CHOs to provide some curative health care for minor ailments, run under-fives clinics, provide family planning counseling and services and run antenatal clinics. The CHFP has also spawned the Female Genital Mutilation Project which seeks to minimize the practice of FGM, which is prevalent in some parts of the Kassena-Nankana district. It is clear therefore that the CHFP reproductive health component has not been too narrow. A lot more remains to be achieved however.

The challenges are daunting but health just cannot wait

Several years ago, a plan was drawn up to introduce an emergency obstetric care programme (EOC) to address the issue of poor obstetric care in the district. The efforts of the CHOs and volunteers have resulted in a massive improvement in antenatal clinic attendance by pregnant women in the district. This has however, not been translated into an increase in the proportion of deliveries in the district supervised by trained health workers since most pregnant women still deliver at home with the assistance of compound members. This is particularly worrying when one considers that maternal and neonatal mortality rates in the district are still much higher than national averages. We envisage a programme that will involve a massive educational campaign targeted mainly at first-time pregnancies. Our expectation is that the momentum built among first time parents will be carried on to subsequent pregnancies. The programme will require communications equipment and appropriate transport to enable prompt referral and evacuation of cases, which require higher levels of care. Training of the CHOs and midwives at the Health Centres and the War Memorial Hospital will be stepped up. Other facilities at the various institutions, for delivery and resuscitation will have to be provided.

There are other areas, which will have to be addressed to ensure that the whole concept of the CHFP has been properly assimilated into the health delivery system. Presently, the CHOs relate very well with the sub-district health apparatus, from where they are supervised. However, linkages to other parts of the healthcare delivery tree have not been explored. This is necessary, not for administrative purposes, but to ensure continuity of services and enhance efficiency. Some patients who are treated in hospital may require follow-ups at home and this can be easily incorporated into the CHO's schedule. For example, patients who are receiving treatment for tuberculosis often default in their treatment once they complete the intensive phase of their treatment and are discharged home. Placing the continuing phase of their therapy under the supervision of the CHOs could improve completion rates. The same arguments can be made for home-based care of people living with HIV/AIDS (PLWHA). Home-based care of PLWHA is now in vogue, because the chronicity of their condition is such that they cannot always be on admission in Hospital and if care can be provided at home for minor problems that develop, then the number of hospital visits can be drastically reduced. This is another scope of work for the CHO that requires further attention. The Ghana AIDS Commission is presently trying to commission research into finding socially acceptable models for home-based care for PLWHA.

The CHFP has really made great strides, which can be attested to, for a long time to come. It behoves us all to try to fill in the remaining gaps, which have opened up with time, to ensure that the people feel the real benefits of 'health for all'."

Send questions or comments to: What works? What fails?
Navrongo Health Research Centre, Ministry of Health, Box 114, Navrongo, Upper East Region, Ghana
What_works?@navrongo.mimcom.net

This series has been launched to share experiences with people in Ghana and elsewhere around the world about what has worked and what has failed in an experiment to make primary health care widely accessible to rural people. The Kassena-Nankana community, whose active participation made *The Navrongo Experiment* possible, are hereby duly acknowledged. This publication was made possible through support provided by the Office of Population, Bureau for Global Programs, Field Support & Research, U.S. Agency for International Development, under the terms of Award No. HRN-A-00-99-00010. The opinions expressed herein are those of the authors and do not necessarily reflect the views of the U.S. Agency for International Development. Additional support was provided by a grant to the Population Council from the Bill and Melinda Gates Foundation. The Community Health Compound component of the CHFP has been supported, in part, by a grant from the Vanderbilt Family to the Population Council.